Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C.

In the Matter of	)	
	)	
Rural Health Care	)	WC Docket No. 02-60
Support Mechanism	)	
	)	

COMMENTS OF VERIZON

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TABLE OF CONTENTS

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Introduction

The Commission should not assume that just because expenditures are not approaching the annual funding cap, the rural health care system is "greatly underutilized" and thus should be changed. *See* NPRM, ¶ 10. As discussed below, the initial estimates for the appropriate funding cap were inflated, and do not set a realistic test for whether the rural health care system is working. For basic telecommunications services, rural rates already are on parity with urban rates in most areas, and thus there is no need to allocate significant funds for that purpose.

At a time when the Commission has recognized that there is "increasing upward pressure" on universal service contributions,[2] the Commission should not look for ways to dramatically expand the scope of support for rural health care. In particular, the Commission should not adopt a general rule that allows subsidization of rural services at rates applied for all "functionally similar" urban services. The Commission also should not expand the definition of "health care providers" or "urban" areas.

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1 The Verizon telephone companies ("Verizon") are the local exchange carriers affiliated with Verizon Communications Inc., and are listed in Attachment A.

2 *See Schools and Libraries Universal Service Support Mechanism*, First Report and Order, CC Docket No. 02-6, FCC 02-175, ¶ 2 (rel. June 13, 2002) (*Schools and Libraries Support Order*).

I. The Commission Should Not Look for Ways to Spend $400 Million, But Should Instead Reduce the Size of the Rural Health Care Cap

A. The $400 Million Funding Cap Was Set at a Level Much Higher than Expected Use, So Failure to Spend Close to the Cap Does Not Indicate that the Fund Is Underutilized

When it initially set the $400 million funding cap, the Commission acknowledged that, unlike programs for which there existed historical data, "there is no existing program to help us estimate the cost of funding the support program for health care providers."[3] The Commission also faced the problem that, "it is difficult to estimate costs given that technologies are developing rapidly and demand is inherently difficult to predict." *Id.* Thus, in order to "ensure sufficient mechanisms," the Commission set a funding cap "based on the *maximum* amount of service that we have found necessary and on *generous* estimates of the number of potentially eligible rural health care providers." *Id.*, ¶ 705 (emphasis added).

However, even as a "maximum" and "generous" estimate, it now appears that the total $400 million cap was set at a level much greater than necessary to meet rural health care needs. As an initial matter, the Commission's estimate assumed that there were "approximately 12,000 health care providers located in rural areas that are eligible to receive supported services under section 254(h)(1)(A)."[4] However, a recent USAC report indicates that the number of eligible rural health care providers is closer to 8,300.[5]

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3 *See Federal-State Joint Board on Universal Service*, 12 FCC Rcd 8776, ¶ 704 (1997) ("*First Universal Service Order*") (subsequent history omitted).

4 *First Universal Service Order*, ¶ 706.

5 *See* NPRM, ¶ 10 & n.17 (citing Universal Service Administrative Company *Report of Health Care Providers Eligible for Support Under the Rural Health Care Universal Service Support Mechanism,* at 4 (April 5, 2002) (stating that as of

Thus, even using the "maximum amount of service" the Commission then assumed would be necessary, if the correct number of eligible providers had been used, the original cap was roughly a third too high.

And even reducing the total to account for one third fewer health care providers, the rural health care cap would be expected to be much higher than needed, because the majority of the original cap was based on an estimate of "the *maximum* cost of providing services eligible for support . . . if *all* eligible health care providers obtain the *maximum* amount of supported services to which they are entitled." *First Universal Service Order*, ¶ 707 (emphasis added). Even when setting the cap, the Commission acknowledged that "the actual cost of support should be lower than our estimate" because the maximum available bandwidth would not be available in all areas, and "many rural health care providers may choose not to use the full amount of support represented by that service." *Id.* Moreover, the Commission's estimates assumed that the rural rate would be higher than the urban rate, even though the record showed that "rates are frequently averaged, a factor that should likewise reduce the amount of support required." *Id.* (footnote omitted).

Likewise, in calculating the cap, the Commission included an estimate of the "maximum" support necessary for rural health care providers to obtain toll-free access to an Internet service provider, by assuming that *all* 12,000 estimated rural health care providers could not already obtain toll-free access. *Id.*, ¶ 708. In addition to the fact that the total number of providers was overstated (from 8,300 to 12,000), the Commission

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September 2000, there were approximately 8,297 health care providers in the United States)).

recognized that this estimate was high, "[b]ecause the record indicates that many rural health care providers can reach an Internet service provider with a local call," or would need less than the full amount of funding, and thus, "the actual cost of support is expected to be lower than our estimate." *Id.* (footnote omitted).

Under the current estimates, the $400 million annual cap would allow *more than $48,000 per year in universal service support for every rural health care provider in the country.*[6] Thus, in order to reach the $400 million cap, not only would *every* eligible rural health care provider in the country have to participate, but the average universal service expenditure per health care provider also would have to be two and a half times higher.[7] When all of the "generous" and "maximum" factors are combined, it is apparent that the cap for rural health care support was set at an amount far greater than necessary to administer the program.

B. Many Rural Rates Already Are "Reasonably Comparable" to Urban Rates, and Thus Rural Health Care Providers Do Not Require Significant Support for Basic Service

Another reason why the Commission's estimate was overly generous is because many of the rate disparities the Act was designed to fix have already been addressed by

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[6] $400 million/8,297 rural health care providers = $48,210 per provider

[7] For the Funding Year 2001, the average expenditure per health care provider was approximately $19,424. ($14.335 million / 738 participating rural health care providers = $19,424 per health care provider). *See* Universal Service Administrative Company, Federal Universal Service Support Mechanism Fund Size Projections for the Third Quarter 2002, at 20 (estimating that Funding Year 2001 demand will be $14.335 million) (May 2, 2002) ("*USAC 3Q2002 Report*"); USAC 2001 Annual Report, at 10 (stating that 738 providers received support). Assuming 100% participation by eligible health care providers, to reach the $400 million cap the current average expenditure ($19,424) must be multiplied by approximately 2.48 (248%) to equal $48,210 for every provider.

other regulatory and market forces. Section 245(h)(1) requires telecommunications carriers to charge health care providers in rural areas "rates that are reasonably comparable to rates charged for similar services in urban areas in that State," and provides universal service support only if the carrier charges the rural health care provider less than "the rates for similar services provided to other customers in comparable rural areas in that State." 47 U.S.C. § 254(h)(1). Thus, universal service subsidies for rural health care providers only occur if "comparable rural areas of the State" are not already receiving rates that are "reasonably comparable" to urban rates.

However, universal service support is not necessary for many basic rural health care providers, because most already receive rates for basic service that are "reasonably comparable" to urban rates. For basic residential and business single-line services, for example, the rates between rural and urban areas are virtually identical, due in large part to state regulatory commission policies designed to promote lower rates in rural and high-cost areas.[8] In addition, one of the initial uses of rural health care funds – to assist those without toll-free Internet access – is dwindling, because "Internet points of presence now exist throughout the country's telecommunications network," calling into question "the need for continuing discounts for toll free access to rural health care facilities." NPRM, ¶ 11. Indeed, industry reports indicate that 97% of those surveyed by the National

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[8] *See* General Accounting Office, *Telecommunications – Federal and State Universal Service Programs and Challenges to Funding*, GAO-02-187, at 15 & Appendix IV (rel. Feb. 4, 2002). For a more detailed discussion of the fact that urban and rural rates already are "reasonably comparable," *see* Verizon Comments, *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, at 4-6 (filed Apr. 10, 2002).

Telephone Cooperative Association reported local dial-up Internet access within their service areas.[9]

C. The Commission Should Lower the Cap, and Should Not Alter the Program in Ways that Would Dramatically Increase the Size of the Universal Service Fund, or that Would Invite Abuse, Waste, or Fraud

When all of the Commission's "maximum" and "generous" estimates are combined with the dwindling need for rural support, it is apparent that the $400 million funding cap was set well above a level "sufficient" to fund the rural health care program. The Commission had no historic data upon which to set established estimates, so setting a generous cap for the rural health care program made sense at the time. However, with the benefit of several years of administration of the rural health care program, the Commission can set a more realistic cap, such as $75 million. Even if the level of participation or support grows by five times the current rate, a revised funding cap of $75 million would be more than sufficient to meet rural health care needs.[10] Setting a more realistic cap also will ensure that the program does not put a strain on an already burdened universal service fund.

Regardless of whether the Commission reduces the cap, it should not look at this proceeding as if it has $400 million (or even $75 million) in the bank that should be spent. As the Commission recently stated, over the past several years there has been "increasing upward pressure" on universal service contributions. *Schools and Libraries*

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9 NPRM, n. 19 (citing NTCA Members Internet/Broadband Survey Report, National Telephone Cooperative Association, at 9 (Nov. 2000)).

10 USAC recently estimated that for Funding Year 2001, $14.335 million would be spent for rural health care. USAC 3Q2002 Report, at 20. ($14.335 million x 5 = $71.675 million). Allowing for a five-fold increase in rural health care funding is far higher than USAC projections of future need. *See id.* (projecting approximately an 18% increase between Funding Year 2001 and Funding Year 2002, to $17.040 million).

Support Order, ¶ 2. Indeed, *additional* funding requirements for the Interstate Common Line Support and Interstate Access Support *alone* "are projected to be over $1 billion in the next year." *Id.*, at n. 10. Any increased funding to the rural health care system will put an additional strain on the fund, and ultimately will be passed on to telecommunications consumers.

If there are necessary services that are not being made available to rural health care providers at rates reasonably comparable to urban rates, and such services could be made available in an economically feasible manner, the Commission should investigate whether changes to the system are necessary. However, especially when consumers bear the ultimate price for increases to the universal service fund, it would be fiscally irresponsible to simply start with an artificially inflated funding cap of $400 million per year, and try to find creative new ways to spend money up to the funding cap level.

II. Any Rule That Treats Similar Services Based On Functionality Should Be Made On A Case-By-Case Basis, And Limited To Situations Where Cheaper Alternatives Are Not Available

The Commission asks how it should define what constitute "similar" services for comparing rural and urban rates. NPRM, ¶¶ 33-40.[11] Currently, it is Commission policy to compare the same or "technically similar" services – for example, comparing the prices of a rural T-1 service to an urban T-1 service. *Id.*, ¶ 34. It seeks comment on whether this policy should be changed so that "discounts would be calculated by comparing services based on functionality of the service from the perspective of the end user." *Id.*, ¶ 35.

[11] Section 254(h)(1)(A) states that a telecommunications provider must give rural health care providers services at "rates that are reasonably comparable to rates charged for similar services in urban areas in that State." 47 U.S.C. § 254(h)(1)(A).

The Commission should not adopt a categorical functional equivalent approach, because it would be largely unnecessary, difficult to administer, and invite abuse and fraud. For several reasons, any "functional equivalent" test should be made on a limited, case-by-case basis, in those instances in which applicants or carriers can demonstrate that it is warranted.

First, as stated above, many telecommunications services already are available in rural areas at rates that are comparable to urban rates, and thus a functional equivalent test is not necessary. Second, for most telecommunications services, making a determination of what is "functionally" similar would be administratively very difficult. One of the difficulties is because there are so many different services available.[12] Compounding any administrative problems is the fact that the Commission would have to make *two* determinations of what "similar" means: (1) what would be the "similar" urban services to which the services available to the health care provider compare; and (2) whether the same test is used to define the "similar" rural services, to determining what, if any, subsidy will apply.[13]

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[12] For example, when the Commission recently invited comment on whether it should require the USAC Administrator to create a list of eligible products and services for the schools and libraries program, several commenters pointed out that because of the sheer volume of products and services potentially available, trying to compile such a list would be an administrative nightmare. *See, e.g.*, Bell South and SBC Joint Comments, *Schools and Libraries Universal Service Support Mechanism*, CC Docket No. 02-6, at 7 (filed Apr. 5, 2002) (offering as an example Bell South Centrex services, which "include five discrete classes of service, each of which includes somewhere between 100 and 425 discrete features or arrangements that may be selected"); Verizon Comments, *Schools and Libraries Universal Service Support Mechanism*, CC Docket No. 02-6, at 11-12 (filed Apr. 5, 2002) (noting that there are "thousands of products and services that would be eligible" and that "there are multiple different names just for Verizon voice services").

[13] The Act states that rural health care providers shall receive services "reasonably comparable to rates charged for *similar services in urban areas* in that State" and that the carrier that provides such rates shall be compensated in "an amount equal to

The Commission would also have to make sure that any functional equivalence rules did not violate competitive neutrality. This might occur, for example, if the Commission were to routinely subsidize satellite rates so that they were equivalent to urban wireline rates. If cheaper rural wireline services were available, such a rule would unfairly subsidize a more expensive service (*e.g.*, satellite) to the less expensive market rate charged for wireline services, thus skewing the market in such services. In addition, if the rural health care provider had available an economical wireline service, such a subsidy would be unnecessary and a potentially expensive waste of universal service funds; the Commission recognized as much in the NPRM.[14] Moreover, because such a rule would be difficult to administer, it would be prone to abuse and fraud, and again risks wasting universal service funds.

In areas where there truly is no economical telecommunications alternative for rural health care providers, the Commission should consider whether to apply a functional equivalence test, *on a case-by-case basis*. For example, such a test might be appropriate for extremely remote areas, such as parts of Alaska, that do not have the same wireline penetration even as other rural areas. However, for other rural areas that have services already available at reasonably comparable rates to urban rates, a functional equivalence test would not be warranted.

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the difference, if any, between the rates for services provided to the health care providers for rural areas in a State and the rates for *similar services provided to other customers in comparable rural areas* in that State. . . " 47 U.S.C. § 254(h)(1)(A) (emphasis added).

[14] "[W]e recognize that widespread use of satellite-based services by rural health care providers that do have reasonably priced land-based alternatives, if fully funded by the rural health care mechanism, may prove costly for the universal service support mechanism and offer an unnecessarily expensive service option for some applicants." NPRM, ¶ 38.

In particular, the Commission should not adopt MSV's proposal for a global rule that "the urban services that are 'similar' to MSV's rural [satellite services] are the terrestrial mobile communications services typically used by ambulances and other emergency medical vehicles in a state's urban areas. . . [and that] support for rural health care providers that use MSV's services should be calculated on the basis of actual airtime usage rates that MSV charges for calls outside a customer's predefined talk-group." NPRM, ¶ 39. MSV has admitted that the cost of its satellite-based services are the same in rural and urban areas, and thus normally would not warrant subsidies. If MSV can demonstrate, for *particular* rural areas, that rural health care providers cannot get economical mobile communications from similar services, the Commission should consider MSV's request for a functionally similar approach *in that particular rural area*.

To ensure competitive neutrality, any subsidy for a particular area should not be in an amount that would make MSV's service the same price as an urban terrestrial mobile service. Rather, in those areas where reasonably comparable rates are not available, the Commission should allow subsidies only in an amount necessary to make the *cheapest* available functionally similar rural service reasonably comparable to the average urban rate, and such subsidies should be available for all providers of similar services. Thus, if a health care provider had a choice between a $60 per month terrestrial mobile service plan or $75 per month for MSV's service, and the average price of the urban mobile service was $40 per month, the health care provider would receive a $20 per month subsidy for whichever service it chose. However, for the reasons stated above, the Commission should not grant a blanket rule in favor of MSV, as it would waste universal service funds, undercut competition and competitive neutrality, and would disadvantage those carriers with similar services that already are being provided at more competitive prices.

III. The Act Does Not Permit Broadening the Definition of Health Care Providers or Comparing Prices to Urban Areas Outside the State

A. The Commission Must Not Expand the List of Eligible Providers

The Commission also asks whether it should change its interpretation of which entities qualify as eligible "health care providers." NPRM, ¶¶ 13-17. Currently, the Commission only allows entities to be eligible for rural health care support if they meet one of the seven statutory categories of "health care providers" set by the Act. In the NPRM, the Commission invites comment on whether it should "revisit [its] prior interpretations of the terms 'health care provider' and 'rural health clinic' to enable rural health care providers to be eligible for discounts even if they or their affiliates also function in capacities that do not fall under the statutory definition in section 254(b)(7)(B)." *Id.*, ¶ 16. Because the Act does not permit such an interpretation, the answer to that question is no.

The Act sets forth a specific list of entities that qualify for universal service support. *See* 47 U.S.C. § 254(h)(7)(B). In setting forth the definition, the Act states that the definition of health care provider "means" one of the types of providers on the enumerated list. "As a rule, '[a] definition which declares what a term 'means' . . . excludes any meaning that is not stated."[15] Therefore, the Commission cannot expand the list beyond that set by the Act.

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[15] *Colautti v. Franklin*, 439 U.S. 379, 392 n. 10 (1979) (quoting 2A C. Sands, Statutes and Statutory Construction § 47.07 (4th ed. Supp. 1978)).

Moreover, the Act specifically prohibits using universal service funds for ineligible entities. *See* 47 U.S.C. § 254(h)(3) (stating that services provided under this section "may not be sold, resold, or otherwise transferred by such user in consideration for money or any other thing of value"). In addition, the Act requires that no "entity" receive universal service under the health care section "if such entity operates as a for-profit business." 47 U.S.C. § 254(h)(4). These prohibitions are set on a whole "entity" or "user" basis, and do not contemplate piece-part allocations of funds within one entity, according to the services provided.

Even if it were not a violation of the Act to expand the rural health care program to entities that have affiliates or parts that are not included in the Act's definition of health care providers, it would be bad policy to expand the definition. As an initial matter, it would be an administrative nightmare to try to determine how funding could be allocated among the proper parts of such entities. The NPRM seeks comment on how such a change would be implemented, and suggests that a pro rata approach might be used. NPRM, ¶ 17. But it is unclear how any pro-rata determination would be made – by revenues, telecommunications usage, or some other criteria? The telecommunications usage certainly would be more consistent with the Act, but would be almost impossible to measure. In addition, it would be incredibly difficult for USAC to audit, especially if the "entity" involved had eligible and ineligible parts within the same building. Moreover, because such a program would be so difficult to monitor and administer, it would not only increase administrative costs, but could invite abuse and fraud. If the wrong allocations were made, it also could drain funds from the universal service program. The

Commission cannot – and should not – change its interpretation of "health care providers."

B. The Act Does Not Allow the Commission to Compare Rates to Urban Areas Outside the State

The Commission also asks whether, for insular areas without significant urban cities, such as Guam and the Northern Mariana Islands, it would be appropriate to use urban cities outside those territories to set the urban rates for which to make the "reasonably comparable" comparison. NPRM, ¶¶ 49-50. The Act plainly states that rural health care rates should be comparable "to rates charged for similar services in urban areas *in that State*." 47 U.S.C. § 254(h)(1)(A). There is no provision of the Act that allows the Commission to designate surrogate out-of-state urban locales for comparison for remote, insular areas that are "relatively rural all over." NPRM, ¶¶ 49-50. Because the statute is clear on its face, the Commission cannot expand the program in ways inconsistent with the statutory language.[16]

IV. The Commission Should Not Change the Definition of Urban Areas

The Act provides that rural health care providers should receive rates that are "reasonably comparable to rates charged for similar services in urban areas in that State." 47 U.S.C. § 254(h)(1)(A). The NPRM asks whether it should change the rules setting the "urban" rate. Currently, the urban rate is based on the rate for similar services in the "nearest large city," which is defined as "the city located in the eligible health care

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[16] *See Chevron U.S.A. v. Natural Res. Def. Council*, 467 U.S. 837, 842-43 (1984) ("If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress").

provider's state, with a population of at least 50,000, that is nearest to the healthcare provider's location . . ." NPRM, ¶ 41. However, because often the largest cities in the states may have "significantly lower rates and more service options than the city of at least 50,000 nearest the rural health care provider," the Commission seeks comment on "whether to alter our rules to allow comparison with rates in any city in a state." *Id.*, ¶ 42.

The Commission should not change the definition of "urban" to any city in the state, as it would be contrary to the Act's purpose and would constitute bad policy. The plain language of the Act shows that it was not designed to give rural health care providers the best possible rates available anywhere in the state. Rather, the statute provides only that the rates be "reasonably comparable" to "urban areas" in the state. If the Commission were to adopt the suggested rule change, rural health care providers would receive rates that would be *better than* those available in most urban areas of the state, and better than the rates available to urban health care providers in the closest urban areas. The Act's language ensures that rural health care providers are not disadvantaged. It certainly does not state that rural health care providers should be treated better than their urban counterparts, and the Commission should not adopt a rule that would create such inequities.

Conclusion

The Commission should reduce the cap for rural health care providers, or at least should not act try to increase universal service spending just because the cap is not being met. The Commission should not change the rules in ways that would be contrary to the Act, or that would invite waste, abuse, or fraud.

Respectfully submitted,

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Attachment A

THE VERIZON TELEPHONE COMPANIES

The Verizon telephone companies are the local exchange carriers affiliated with Verizon Communications Inc. These are:

Contel of the South, Inc. d/b/a Verizon Mid-States
GTE Midwest Incorporated d/b/a Verizon Midwest
GTE Southwest Incorporated d/b/a Verizon Southwest
The Micronesian Telecommunications Corporation
Verizon California Inc.
Verizon Delaware Inc.
Verizon Florida Inc.
Verizon Hawaii Inc.
Verizon Maryland Inc.
Verizon New England Inc.
Verizon New Jersey Inc.
Verizon New York Inc.
Verizon North Inc.
Verizon Northwest Inc.
Verizon Pennsylvania Inc.
Verizon South Inc.
Verizon Virginia Inc.
Verizon Washington, DC Inc.
Verizon West Coast Inc.
Verizon West Virginia Inc.